Monroe County Early Intervention Program
Referral Form
(585) 753-5437 fax (585) 753-5272

Date: _____

Name and title of referral source: _____

Agency Name: _____

Phone number: _____

Address (include zip code): _____

Reason for referral (See EI Referral Guidelines) _____

_____

Child's name: _____ **DOB:** _____ **Sex: M___F__**

Child's Gestational Age: _____ **Hearing Impaired:** o Yes o No

Child's race: _____ **Primary Language:**_____

Hispanic: o Yes o No **Speaks English:** o Yes o No

Child's address (include zip code): _____

Child's phone number: _____ **Alternate #:** _____

Child's school district: _____

Insurance Name: _____ **Number:** _____

Health Care Provider: _____ **Phone:** _____

Address (include zip code): _____

Biological mother's name:_____ **DOB:** _____

Foster parent's name:_____ **DOB:** _____

Household Members (of child):

Name:_____ **DOB:** _____ **Relationship:** _____

Name:_____ **DOB:** _____ **Relationship:** _____

Name:_____ **DOB:** _____ **Relationship:** _____

Name:_____ **DOB:** _____ **Relationship:** _____

Medical History:

_____

_____

_____

_____

If Child Protective/Foster Care involved, include caseworker name and phone number:

_____

Other Comments: _____

_____